Family Support Services—Family Reimbursement for Goods & Services, Application for 2019

Dear Family Member/Caregiver:

Living Resources Corporation's Family Support Services (FSS)—Family Reimbursement for Goods & Services program provides financial assistance to families in New York State who live with a family member diagnosed with a developmental disability. This service can provide financial reimbursement to families who have had to buy necessities for their loved one with ID/DD, up to $200 per family each year. The Family Support Services (FSS) Coordinator brings together a committee consisting of programming staff and family members of people receiving OPWDD services to review applications for reimbursement. Reimbursement grants are distributed to approved applications on a quarterly basis.

Applications must be turned into our office by the following dates in order to be considered for approval:

- Quarter 1: Friday, February 15th, 2019
- Quarter 2: Friday, May 17th, 2019
- Quarter 3: Friday, August 16th, 2019
- Quarter 4: Friday, November 15th, 2019

The committee takes into consideration any special request regarding these deadlines as long as the recipient contacts the FSS Coordinator to review the circumstances on an individual basis.

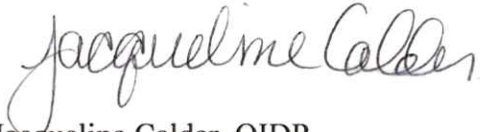
Requests are reviewed on an anonymous basis; only the FSS Coordinator will know applicants' names for proper dispersal of funds. Decisions are based on the following: eligibility for OPWDD services, financial need of the applying family, the necessity of the item for which the family seeks reimbursement, previous grants received by the family, and how the grant will improve the individual's and family's quality of life. Anyone submitting an application will need to include the following:

- A completed grant application
- A detailed justification for the request
- If you are requesting a service or item, the agency requires a statement from the vendor stating the cost of the item/service and mailing address
- For items already purchased, please include the receipt with your application (We cannot pay for items purchased prior to the current approval year)
- Families who are new to OPWDD funded Family Support Services must now connect with their Front Door Liaison
- Families who are in Self-Direction must note that on the application and include broker information. Self-Direction Budget amendments must be submitted to Living Resources Corporation should the individual receive a grant.

After the FSS Family Reimbursement Committee has met, the agency will contact you via mail as to the decision of the committee. Letters of approval or denial will be generated within one month of the meeting date. Unfortunately, we are not always able to approve all requests.

Thank you for applying to Living Resources Corporation for a FSS grant. Please contact Jacqueline Calder, FSS Coordinator, at jcalder@livingresources.org or at 518-218-0000 ext. 5414 with any questions or assistance needed in completing the application.

Best,



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Application for Family Support Services—Family Reimbursement for Goods & Services Grant, 2019

Name of Applicant (Person with OPWDD Eligibility):______________________________
Street Address:____
City:____________________ State:____________ Zip Code:______________
DOB:____________________ Gender: Male / Female / Other (please circle one)
SSN: ______________ Medicaid #:______________ TABS ID:______________

Persons Living in the Home (only parent(s)/guardians and children under 18):
Parent/Guardian (First & Last Name): __________________________________
Telephone Number:_________________ E-mail Address:______________________
Parent/Guardian (First & Last Name): __________________________________
Telephone Number:_________________ E-mail Address:______________________
Parent/Guardian (First & Last Name): __________________________________
Telephone Number:_________________ E-mail Address:______________________
Children Under 18 (do not include applicant):
Name:____________________ Relationship:______________ Age:__________
Name:____________________ Relationship:______________ Age:__________
Name:____________________ Relationship:______________ Age:__________
Name:____________________ Relationship:______________ Age:__________
Name:____________________ Relationship:______________ Age:__________

Family's Annual Gross Income (including SSI/SSDI):____________________________

Contacted Front Door Liaison? (Please circle one) Yes / No / N/A Date:______________
Enrolled in Self-Direction? (Please circle one) Yes / No / Not Yet / In the Process
If "Yes" or "In the Process": Broker Name & Contact: ____________________________
____

Is the applicant currently applying elsewhere with this same reimbursement request? Yes / No

____
Agency Name Phone Number Date Requested

____
Agency Name Phone Number Date Requested

*Please note that by completing this application, you give permission to Living Resources Corporation to contact other agencies regarding your reimbursement request.

Care Manager Information (best completed by or with the Care Manager):

Is the applicant enrolled in the Medicaid Waiver? Yes / No / Pending (please circle one)

Care Manager's Name:____
Agency Name:________________________________ Phone #:_______________________
Street Address:____
City:_______________________ State:______________ Zip Code:__________________
E-mail Address:____

Please list any other Waiver and/or Respite Services the applicant receives:

Type of Service	Agency Providing Service	Contact Person & Information	Frequency the service is received
Care Management			
Community Habilitation			
In-Home Waiver Respite			
Free Standing Respite			
Early Intervention			
School			
Day Program			

Disability Information: Please check those that apply:
Intellectual Disability_____ Cerebral Palsy_____ Epilepsy_____ Autism_____ TBI_____
Down Syndrome_____ Visually Impaired_____ Hearing Impaired______ Spina Bifida______
Other____

Any other medical concerns:____
____
____
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Please indicate any major shifts in the family dynamic within the past year that has caused undue hardship (ex: loss of a job, hospitalization, death, etc): ______________________________
____
____
____
____
____

Other Grant Information:

Please list all grants that the applicant has received since the beginning of the current calendar year:

Item(s) Received	Agency Name	Cost of Item	Date Received
Item(s) Received	Agency Name	Cost of Item	Date Received
Item(s) Received	Agency Name	Cost of Item	Date Received
Item(s) Received	Agency Name	Cost of Item	Date Received

Has the applicant been denied for this request this calendar year? Yes / No (please circle one)

Agency Name	Phone Number	Date Requested

Reason for Denial

What expenses do you have related to your family member's disability? ___________________

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____

____

____

What health insurance do you/your family currently have?_______________________________

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____

Specify the service/item you are requesting by checking the appropriate line below:

Personal Care Supplies_____ Environmental Modifications _____
Tuition or fees to a program (ex: camp)_____ Tutor_____ Adaptive Equipment_____
Other (specify)____

Amount Requested $________________ Price of Item: $____________________

If your current request is for Adaptive Equipment, Environmental Modifications, or Medical Requests/Services, you will need to include:

- Adaptive Equipment: A minimum of three estimates for applicable items
- Adaptive Equipment, Environmental Modifications, Medical Requests/Services:
    - a denial letter from Medicaid, private insurance, or Waiver Service for applicable items
    - A note from a doctor/clinician supporting the service denied by Medicaid/private insurance

Please describe in detail how this service/item would enhance you and/or your family's life (include additional pages if needed)____

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Signature (required):

Applicant	Print Name	Date
Parent/Guardian	Print Name	Date
Care Manager	Print Name	Date